STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155176	B. WIN			11/19/	2012
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CENT	ER	FORT	VAYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
F0000	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)		DATE
1 0000							
	This visit was for	or a Recertification and	F00	00	Glenbrook Rehabilitation and		
	State Licensure				Skilled Nursing Center is		
		,			requesting a desk review of th		
	Survey dates: I	November 13, 14, 15,			submitted plan of correction. Very have attached documents	Ve	
	16, and 19, 20				supporting the identified CQI		
					tools, trainings, and audits to b	ре	
	Facility number	r: 000092			utilized in correcting the cited		
	Provider numb	er: 155176			items. If you have further questions please contact Greg	10	
	AIM number: 100266090				Fuller Executive Director. We	99	
					thank you for your consideration	on	
	Survey team:				in this matter		
	Diane Nilson, F	RN- TC					
	Angela Strass,	RN					
	Sue Brooker, F	RD					
	Rick Blain, RN						
	Census bed typ	ne.					
	SNF/NF: 74	JC.					
	Total: 74						
	Census payor t	type:					
	Medicare: 12						
	Medicaid: 54						
	Other: 8	}					
	Total: 74						
	These deficien	cies reflect State					
	findings cited in	n accordance with 410					
	IAC 16.2.						
	o						
	Quality review	•					
		2012 by Bev Faulkner,					
	RN						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

SHG911

Facility ID:

000092

TITLE

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2012 FORM APPROVED OMB NO. 0938-0391

	FOF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155176	(X2) MULTIPLE CO  A. BUILDING B. WING	00  ADDRESS, CITY, STATE, Z	COM	TE SURVEY MPLETED 19/2012	
	ROVIDER OR SUPPLIE DOK REHABILITA	R ATION & SKILLED NURSING CEI	3811 P.	ARNELL AVE WAYNE, IN 46805	AI CODE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TO DEFICIENCY	F CORRECTION ON SHOULD BE THE APPROPRIATE Y)	ON (X5) BE COMPLETION PRIATE DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SHG911

Facility ID: 000092

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE C	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING OO COMPLETED			ETED	
		155176	B. WIN			11/19/	2012
			b. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L			PARNELL AVE		
OLENDO		TION & CIVILLED NUDCING CENT	ren				
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CEN	IEK	FURT	WAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
F0241	483.15(a)						
SS=D	DIGNITY AND RE	ESPECT OF					
	INDIVIDUALITY						
	The facility must	promote care for residents					
	in a manner and i	in an environment that					
	maintains or enha	ances each resident's					
	dignity and respe	ct in full recognition of his					
	or her individuality	y.					
			F02	41	F 241 Dignity and Respect of		11/30/2012
					Individualit		
	Rased on ohse	ervation, interview and			It is the practice of this provide	r to	
		·			promote care for all residents	n a	
		the facility failed to			manner and in an environmen	t	
	_	staff knocked on			that maintains or enhances ea	ch	
	resident doors	and waited for a			resident's dignity and respect.		
	response prior	to entering the			DNS interviewed Resident #26		
	resident's room	n. This potentially			and #53 affected by the deficie		
		dents (#26 and #97) of			practice. Both Resident #26 a		
		ho resided on the 300			#53 did not report a loss of dig		
		no resided on the 300			or respect by Nurse #1. Nurse	#1	
	hall.				and Nurse #2 have been	4	
					re-educated to knock on reside		
	Finding Include	es:			door and wait for a response p	rior	
	_				to entering residents' rooms.		
	On 11/16/12 at	: 8:20 a.m., Nurse #1			Other residents on the same		
		·			hallway were interviewed and		
		dent #26's medications.			report that staff knocks on their	r	
		t through the open			doors and waits for a response		
	door of the resi	ident's room saying			prior to entering their rooms.		
	"Knock. Knock.				staff in serviced on 12/4/12 by		
					DNS and designees in regards		
	On 11/16/12 at	: 11:40 a.m., Nurse #1			knocking on residents' doors a		
		ent #97's room to give			waiting for a response prior to		
		_			entering.		
		irse #1 did not knock					
		's door, she called the			All staff in serviced on 12/4/12	to	
	resident by nar	me and walked in			knock on doors and wait for		
	without waiting	for the resident to give			response prior to entering		
	permission.	Ü			resident's room. DNS and		
	P 3				designees will monitor the		
					resident rooms daily to ensure		

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Event ID: SHG911

Facility ID: 000092

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	I DINC	00	COMPLE	TED
		155176	A. BUI B. WIN	LDING		11/19/2	012
			B. WIN		DDDFGG CITY CTATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
01 51155	0014 DELLA DILLEA	TION A OWN FR AN IRON O OFN			ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CEN	IER	FORTV	VAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	'E	DATE
	Observation or	n 11/16/12 at 3:00 p.m.,			that staff are knocking on door	rs	
		red Resident #26's			and waiting for response prior		
	•				entering resident's rooms.		
		ound treatment. The					
		erved to walk half way			DNS and designees will monit		
	into the room,	back out of the room			using the dignity and privacy C		
	and then call th	ne resident's name and			form for compliance daily for 2		
	then knock on	the door. The nurse			weeks, then weekly for 2 mont		
		to the room without			then quarterly for 6 months an		
		resident to respond.			forward results to monthly CQ	I	
	waiting for the	resident to respond.			committee for review. If any		
					findings are out of compliance		
		t 2:30 p.m., review of			then additional monitoring and		
	the "Facility Or	ientation for			additional action plan will conti as determined by the committe		
	Employees" in	formation indicated			Compliance threshold is 90%.	<del>.</del>	
	"Remember to				Non-compliance may result in		
	resident's door				disciplinary action up to and		
					including termination.		
	_	nber, you are in the			including termination.		
	resident's hom	e."			Systemic changes will be		
					completed by 12/4/12.		
	Interview with	the Director of Nursing					
		2:34 p.m., indicated					
		ock and wait to enter					
	resident rooms	j.					
	3.1-3(t)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SHG911

Facility ID: 000092

If continuation sheet Page 4 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155176	A. BUIL B. WING			11/19/	2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CENT	ER		ARNELL AVE VAYNE, IN 46805		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN		PROVIDER'S PLAN OF CORRECTION	AN OF CORRECTION	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
F0279 SS=D	PLANS A facility must use assessment to de	P(k)(1) PREHENSIVE CARE  The the results of the evelop, review and revise expressive plan of care.					
	care plan for each measurable object meet a resident's mental and psych	develop a comprehensive in resident that includes stives and timetables to medical, nursing, and losocial needs that are omprehensive assessment.					
	that are to be furn the resident's high mental, and psych required under §4 that would otherw §483.25 but are n resident's exercis including the right §483.10(b)(4).	st describe the services hished to attain or maintain hest practicable physical, hosocial well-being as 483.25; and any services rise be required under not provided due to the e of rights under §483.10, at to refuse treatment under					
	Based on recordinterview, the factor a care plan to a was developed who met the cr (Resident #41)  Findings include The record for reviewed on 11  A Minimum Date (MDS), dated 9	acility failed to ensure address impaired vision for 1 of 18 residents iteria for vision	F02'	79	F279 Develop Comprehensive Care Plans: It is the practice of this facility use the results of the assessm to develop, review, and revise resident's comprehensive plan care. Social Services develope care plan for impaired vision for Resident #41 to include reside refusal to wear glasses dated 11/19/2012.  All residents who have impaired vision have the potential to be affected by the same deficient practice. Social Services to review all residents with impair vision to ensure that a care plan.	to nent the n of d a or ent's	12/02/2012

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Event ID: SHG911

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPL	ETED
		155176		LDING		11/19/	2012
		<u> </u>	B. WIN		ADDRESS CITY STATE ZIR CORE		
NAME OF P	ROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE		
OL ENDD	OOK DELIABILITA	TION & OKU LED NU IDOING OFN	TED		ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CEN	IEK	FORT	WAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The Care Area	Assessment (CAA)			is in place.		
	Summary, date	ed 9/17/12, indicated					
	_	oses not to wear			All new admissions to the facil		
		ad difficulty reading			are assessed for vision needs a licensed nurse on the nursin		
	_	ng interview of 9/17/12.			assessment. SS will be	y	
	•	ropel wheelchair safely			in-serviced by the ED or design	inee	
	•	•			to ensure care plans will be		
		s large print for written			completed when the resident i	S	
		e CAA indicated a care			identified to have vision		
	•	developed to address			impairment.		
	the resident's i	mpaired vision.					
					Social Services and/or design		
	A review of Re	sident #41's record did			will utilize the Vision CQI form		
	not indicate a	care plan to address			weekly for 4 weeks, monthly for months, and then quarterly for		
		n had been developed.			months thereafter to monitor for		
	inipanoa violoi	. Had 2001 dovoloped.			compliance. Results will be	<i>J</i> 1	
	The facility's S	ocial Services Director			forwarded to the CQI committee	ee	
	_				monthly for review. An addition		
	, ,	erviewed on 11/19/12 at			action plan will be developed	or	
		ing the interview, the			any findings below the thresho		
		she performed the			of 90%. MDS and/or designed		
	vision screenir	ngs for the MDS			will use the care plan updating		
	assessments a	and was responsible for			CQI form weekly for 4 weeks,		
	developing car	e plans for impaired			then monthly for 3 months, an then quarterly for 6 months	u	
	vision if indicat	ted. The SSD reviewed			thereafter to monitor for		
		care plans and was			compliance. Results will be		
		ide a care plan			forwarded to the CQI committee	эе	
	•	paired vision. During			monthly for review. An addition		
		_			action plan will be developed	or	
	-	he SSD indicated a			any findings below the thresho		
	=	Resident #41's impaired			of 90%. Non-compliance may		
		nave been developed,			result in disciplinary action up	to	
	· ·	to address the			and including termination.		
	resident's impa	aired vision had not			Systemic changes will be		
	been develope	ed.			completed by 12/2/12.		
	•				Completed by 12/2/12.		
	A facility policy	entitled "Care Plan					
		aintenance Process					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155176			A. BUI	LDING	NSTRUCTION  00	(X3) DATE ( COMPL 11/19/	ETED
		100170	B. WIN		DDDEGG GITW GTATE ZID GODE	11/19/	2012
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
		TION & SKILLED NURSING CEN	TER		VAYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG		indicated "It is the		IAG			DATE
		cility that each resident					
		nprehensive care plan					
		ed on comprehensive					
	assessment."	•					
	3.1-35(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SHG911

Facility ID: 000092

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155176	A. BUII B. WIN			11/19/	2012
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L					
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CENT	ER		ARNELL AVE VAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	12	DATE
F0441 SS=D	483.65 INFECTION CON SPREAD, LINEN The facility must of Infection Control provide a safe, safe environment and development and and infection.  (a) Infection Control The facility must of Control Program (1) Investigates, of infections in the facility must of Control Program (2) Decides what isolation, should be resident; and (3) Maintains a recorrective actions (b) Preventing Sp (1) When the Infed determines that a prevent the spread must isolate the recommunicable beliesions from direct their food, if direct disease. (3) The facility must be for which hand we accepted profess (c) Linens Personnel must he	establish and maintain an Program designed to anitary and comfortable to help prevent the transmission of disease establish an Infection under which it controls, and prevents acility; procedures, such as be applied to an individual ecord of incidents and a related to infections.  In the procedure of the ection ection Control Program establish and in ection in the ection of the ection of the ection of the ection in ection Control Program eresident needs isolation to ad of infection, the facility esident. East prohibit employees with disease or infected skin ect contact with residents or ection contact with residents or ection contact will transmit the each direct resident contact ashing is indicated by ional practice.		TAG	DEFICIENCY		DATE
	of infection.	o as to prevent the spread					
		ervation, interview, and the facility failed to	F04	41	F441 Infection Control, Prever Spread, Linens	nt	12/04/2012

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Event ID: SHG911

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155176	B. WIN			11/19/	2012
		1	b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CEN	TER		WAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI			COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	ensure staff wa	ashed hands before			It is the practice of this facility	to	
	and after wear	ing exam gloves during			establish and maintain an		
	1 of 1 observat	tions of medication			Infection Control Program designed to a provide a safe,		
	administration	through a gastrostomy			sanitary and comfortable		
	tube (G-tube) a	affecting 1 resident			environment and to help preve	ent	
	(Resident #80)	•			the development and		
	(	,			transmission of disease and		
	Findings include	<del>ا</del> ه٠			infection. LPN #3 was		
	Tilldingo illoide				re-educated on G-tube care po		
	Op 11/16/12 of	t 11:55 A.M., LPN #3			policy and a skills validation for G-tube medication administrat		
		,			was completed. Resident #80	-	
		in the hallway at the			receiving g-tube care with	13	
	medication car				appropriate infection control		
		be administered to			procedures.		
		hrough a G-tube			All residents who receive		
	(feeding tube).	The LPN was not			medications via a G-tube have		
	observed to wa	ash her hands or to use			the potential to be affected by	the	
	hand sanitizer	prior to preparing the			alleged deficient practice. All nurses will complete a G-tube		
	medications.	The LPN was observed			medication administration skill	9	
	to enter Reside	ent #80's room to			validation check-off with infect	_	
	administer the	medications. The LPN			control guidelines by DNS and		
		to put on disposable			designee by 12/4/12. An all sta	aff	
		nd administer the			in-service will be held on 12/4/		
	_	rough the g-tube. The			for infection control and glovin	g	
		bserved to wash her			by DNS and/or designee.		
					All nurses to complete a G-tub	ne.	
		e hand sanitizer prior to			medication administration skill		
		exam gloves. The LPN			validation check-off with infect		
		administration of the			control guidelines by 12/4/12 a		
		nd removed the exam			an all staff in-service on 12/4/		
	~	posed of them in a			for infection control and glovin		
	waste basket.	The LPN then left the			by DNS and/or designee.All no		
	room and retur	ned to the medication			nursing staff will complete G-to medication administration and		
	cart and docur	nented the			gloving skills validations upon		
	administration	of the medications on			and quarterly thereafter by DN		
		The LPN was not			and/or designee. DNS /design		
	-	ash her hands or to use			will conduct rounds on all shift		
	l observed to Ma	asii ner nanus or to use	1		conduct rounds on all silling	0	

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Event ID: SHG911

Facility ID: 000092

If continuation sheet

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155176	A. BUII			11/19/	2012
			B. WIN		DDDECC CITY CTATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIE	2			ADDRESS, CITY, STATE, ZIP CODE		
OL ENDD	OOK DELIABILITA	TION & OKULLED NUIDOING OFNI			ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CENT	EK	FORTV	VAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	hand sanitizer	after removing the			ensure appropriate infection		
exam gloves and returning to the				control procedures are followed	ed		
	medication cart.				for g-tube care.		
	modrodion odi				DNO 1/ 1 : 31 (31)		
	The Facility Di	rector of Nursing (DON)			DNS and/or designee will utilize the Infection Control COL wool		
	•	<u> </u>			the Infection Control CQI weel x 4 weeks, then monthly	r.i y	
		ed on 11/19/12 at 1:50			thereafter for at least 6 months	s	
	_	ne interview, the DON			Results to be forwarded to CC		
		were to wash hands			monthly for review. An addition		
	before putting	on exam gloves and			action plan will be developed f		
	after removing	exam gloves when			threshold below 90%.		
	providing resid	ent care.			Non-compliance may result in		
					disciplinary action up to and		
	On 11/10/12 a	t 2:30 P.M., the facility			including termination.		
		-					
		ctor of Nursing (ADON)			Systemic changes to be		
		acility hand washing			completed by 12/4/12.		
	policy did not a	address glove usage					
	and hand wash	ning. The ADON					
	provided a Skil	lls Validation checklist					
	entitled "Glove	s", dated 3/2012, and					
	indicated the c						
		be the facility's policy.					
		ndicated staff were to					
		ior to putting on exam					
	gloves and afte	er removing the gloves.					
	3.1-18(I)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SHG911

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